Oregon Ear, Nose and Throat Center

Patient Name:_______________________________ Date of Birth:_______________ Age: _______ Gender: M F

Reason for today's visit:____

Current List of Medications. List name, dosage and frequency. Include supplements (vitamins, herbals, etc).

____

____

____

____

Allergies to Medications:____

Does patient have a history of a bleeding disorder? Y N Allergic to Eggs? Y N Allergic to Soy: Y N

Does patient have a personal history of anesthesia reaction? Y N Details:____

Does family member have a history of anesthesia reaction? Y N Details:____

Past Medical History: (CHECK THE BOX NEXT TO THE CONDITION THE PATIENT HAS NOW OR HAD IN THE PAST)

- ☐ Latex allergy - YES
- ☐ Latex allergy - NO

Eyes
- ☐ Glaucoma
- ☐ Cataract

ENT
- ☐ Hearing loss
- ☐ Cholesteatoma
- ☐ Recurrent tonsillitis
- ☐ Chronic sinusitis
- ☐ Nasal polyps
- ☐ Broken nose
- ☐ Broken facial bones
- ☐ Obstruct sleep apnea
- ☐ Meniere's Disease
- ☐ Otosclerosis

Cardiovascular
- ☐ Hypertension
- ☐ Coronary artery disease
- ☐ Atrial fibrillation
- ☐ Other arrhythmia
- ☐ Congestive heart failure
- ☐ Valvular heart disease
- ☐ Varicose veins/phlebitis

Respiratory
- ☐ Asthma
- ☐ COPD
- ☐ Lung cancer

Gastrointestinal
- ☐ GERD
- ☐ Peptic ulcer
- ☐ GI bleed
- ☐ Liver disease
- ☐ Cirrhosis
- ☐ Colon cancer
- ☐ Crohn's disease
- ☐ Diverticulitis
- ☐ Renal failure
- ☐ Kidney disease
- ☐ Prostate enlarged
- ☐ Prostate cancer
- ☐ UTI-Recurrent
- ☐ Infertility

Musculoskeletal
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Rheumatoid arthritis
- ☐ Broken bones
- ☐ Muscular dystrophy

Neurologic
- ☐ CVA/Stroke
- ☐ Brain tumor
- ☐ Seizure disorder
- ☐ Multiple sclerosis
- ☐ Anxiety
- ☐ Depression
- ☐ Bipolar
- ☐ Schizophrenia

Endocrine
- ☐ Diabetes Type I
- ☐ Diabetes Type II/oral
- ☐ Hypothyroidism
- ☐ Hyperthyroidism
- ☐ Thyroid disorder

Skin
- ☐ Skin disease

Hem/Lymphatic
- ☐ Cancer
- ☐ Anemia
- ☐ Blood transfusion
- ☐ Hyperlipidemia
- ☐ Hypercholesterolemia
- ☐ Deep vein thrombosis
- ☐ Hemochromatosis

Allergy/Immunologic
- ☐ Allergic rhinitis
- ☐ Fibromyalgia
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Tuberculosis
- ☐ MRSA
- ☐ HIV/AIDS
- ☐ VRE
- ☐ C. Difficile

OTHER:_____________________________

Past Surgical History:

ENT
- ☐ M&T (ear tubes)
- ☐ Stapedectomy
- ☐ Septoplasty
- ☐ Rhinoplasty
- ☐ Rhytidectomy (face lift)
- ☐ Sinus surgery

Skin/Cardio/Resp
- ☐ Skin cancer removal
- ☐ AV fistula
- ☐ AV graft
- ☐ Port placement
- ☐ Aortic valve replacement
- ☐ Mitral valve replacement

Eyes/Gastro/GU
- ☐ Cataract
- ☐ Lens replacement
- ☐ Blepharoplasty
- ☐ Abdominal surgery
- ☐ Appendectomy
- ☐ Cholecystectomy (gall bladder)

MS/Neuro
- ☐ Back surgery
- ☐ Carpal tunnel
- ☐ Hip replacement
- ☐ Knee replacement
- ☐ Knee arthroscopy
- ☐ Kyphoplasty

PATIENT NAME AND DATE OF BIRTH:____

Past Surgical History (continued):

ENT
- □ Adenoidectomy
- □ Tonsillectomy
- □ UP3
- □ Tracheotomy
- □ Thyroidectomy
- □ Parathyroidectomy
- □ Parotidectomy left
- □ Parotidectomy right
- □ Submandibular gland excision left
- □ Submandibular gland excision right
- □ Neck dissection left
- □ Neck dissection right

Skin/Cardio/Resp
- □ Pacemaker
- □ Vascular bypass
- □ Carotid endarterectomy
- □ CABG (heart bypass)
- □ Bronchoscopy
- □ Lung resection left
- □ Lung resection right

Eyes/Gastro/GU
- □ Colon resection
- □ Gastric bypass
- □ Hemorrhoidectomy
- □ Kidney removal
- □ TURP
- □ Prostatectomy (open)
- □ Hysterectomy
- □ Cesarean section
- □ D&C
- □ Tubal ligation

MS/Neuro
- □ Rotator cuff repair
- □ Interventional pain procedure
- □ Craniotomy/ brain surgery
- □ Amputation
- □ Brain tumor

For any surgeries you have undergone, did you have any of the following:

- □ **Anesthesia problem:** **Yes** **No**
- □ **Surgical complications:** **Yes** **No**
- □ **Post-Op delirium:** **Yes** **No**

OTHER:____

Family History:

Please indicate relation of family member for any checked boxes below. (M = mother, F = father, B = brother, S = sister, D = daughter, SC = son, GM = grandmother, GF = grandfather)

	Relation:
□ Alcoholism	_________
□ Allergy	_________
□ Anesthesia problems	_________
□ Anemia	_________
□ Angina	_________
□ Anxiety	_________
□ Arthritis	_________
□ Asthma	_________
□ Bleeding disorder	_________
□ Breast cancer	_________
□ Cancer (type)	_________
□ Depression	_________
□ Diabetes	_________
□ Growth/Devt. disorder	_________
□ Headaches	_________
□ Hearing loss	_________
□ Heart disease	_________
□ High blood pressure	_________
□ High cholesterol	_________
□ Migraines	_________
□Osteoporosis	_________
□ Psychiatric care	_________
□ Renal disease	_________
□Seizures	_________
□Severe Allergies	_________
□ Suicide	_________
□ Thyroid disorder	_________
□ Weight disorder	_________

Social History:
- □ Occupation _________________
- □ Minor
- □ Single
- □ Married
- □ Divorced
- □ Separated
- □ Widowed
- □ Children – Yes- how many:______
- □ Children – No
- □ Lives alone - Yes
- □ Lives alone - No
- □ History of domestic abuse
- □ Religion affecting care
- □ Immunizations current:
- □ Yes □ No □ Unknown

Tobacco Use:

Current Everyday Smoker: Y N
Former smoker: Y N
Calendar year started: _________
Calendar year quit: _________
Cigarettes: Y N Amount/week:________
Cigars: Y N Amount/week:________
Smokeless: Y N Amount/week:________
Counseled to quit/cut down: Y N
Passive smoke exposure: Y N

Alcohol Use: Y N

If yes, type: ____________
Drinks per day: ____________
Drinks per year: ____________
Drinks per week:________
Counseled to quit/cut down: Y N
Comments:___________________________
____

PATIENT NAME AND DATE OF BIRTH:____

Review of Systems: (CHECK THE BOX NEXT TO THE CONDITION THE PATIENT IS ***CURRENTLY*** EXPERIENCING)

General

□ Chills
□ Fever
□ Sweats
□ Fatigue
□ Weight loss

Eyes

□ Loss of vision
□ Double vision
□ Blurred vision
□ Eye pain
□ Wear glasses/contacts

ENT

□ Hearing loss right
□ Hearing loss left
□ Hearing loss both ears
□ Hearing aids right
□ Hearing aids left
□ Hearing aids both ears
□ Ear pain right
□ Ear pain left
□ Ear pain both ears
□ Ear drainage right
□ Ear drainage left
□ Ear drainage both ears
□ Ringing in ear right
□ Ringing in ear left
□ Ringing in ear both
□ Nosebleeds right
□ Nosebleeds left
□ Nosebleeds bilateral
□ Snoring
□ Nasal congestion
□ Nasal drainage/discharge
□ Loss of smell
□ Dental pain/problems
□ Mouth sores
□ Sore throat
□ Hoarseness/voice change
□ Difficulty swallowing

Cardiovascular

□ Chest pain/discomfort
□ Shortness of breath with exertion
□ Palpitations
□ Swelling hands/feet

Respiratory

□ Cough
□ Shortness of breath
□ Coughing blood
□ Wheezing

Gastrointestinal

□ Heartburn/reflux
□ Vomiting blood
□ Nausea/vomiting
□ Abdominal pain

Genitourinary

□ Trouble starting/stopping urination
□ Painful urination
□ Bloody urine

Musculoskeletal

□ Arthritis
□ Arm pain
□ Back pain
□ Leg pain
□ Joint swelling
□ Joint pain

Skin

□ Suspicious lesions
□ Poor wound healing
□ Skin cancer
□ Rash

Neurologic

□ Sensation of room spinning
□ Poor balance
□ Headaches
□ Loss of coordination
□ Numbness
□ Speech difficulty
□ Falling down
□Seizures
□ Fainting

Psychiatric

□ Anxiety
□ Depression
□ Mental problems
□ Suicidal thoughts

Endocrine

□ Cold intolerance
□ Heat intolerance
□ Excessive hunger
□ Excessive thirst

Heme/lymphatic

□ Enlarged lymph nodes
□ Easy bleeding or bruising
□ Blood transfusion
□ Cancer
□ Anemia

Allergic/Immunologic

□ Seasonal allergies
□ Hives or rash
□ Food allergies
□ HIV exposure